



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

Northwest Texas Healthcare

Respondent Name

Liberty Mutual Insurance

MFDR Tracking Number

M4-15-1949-01

Carrier's Austin Representative

Box Number 01

MFDR Date Received

March 2, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "As these services were not subjected to a prior medical necessity review, we ask that you evaluate the treatment in question pursuant to 28 Tex. Admin. Code 19.2015 (Regarding "Utilization Review for Healthcare Provided under Worker's Compensation Insurance Coverage") This section specifically allows for "Retrospective Review of Medical Necessity," and requires carriers to perform "such retrospective... under the direction of a physician."

Amount in Dispute: \$136.64

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "28 TAC 134.600 (P) specified the services that require preauthorization under Division rules. This service was denied as the preauthorization requirements of 134.5 were not met..."

Response Submitted by: Liberty Mutual

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 4, 2014	97010, 97033, 97035, 97124	\$136.64	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.600 sets out the guidelines for prospective and concurrent review of healthcare.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
 - 170 – Preauthorization was required, but not requested for this service
 - 193 – Original payment decision is being maintained

Issues

1. Was prior authorization required?
2. Is the requestor entitled to reimbursement?

Findings

1. The requestor in their position statement state, "pursuant to 28 Tex. Admin. Code 19.2015 (Regarding "Utilization Review for Healthcare Provided under Worker's Compensation Insurance Coverage") This section specifically allows for "Retrospective Review of Medical Necessity," and requires carriers to perform "such retrospective... under the direction of a physician." The Texas Register, Title 28, Rule §19.2015 (2), in pertinent part states, " such retrospective review shall be under the direction of a physician and performed in accordance with Chapter 133, Subchapter D of this title (relating to Dispute and Audit of Bills by Insurance Carriers). These services were not denied for medical necessity. The disputed services were denied for lack of pre-authorization as required by 28 Texas Administrative Code §134.600 (p) "Non-emergency health care requiring preauthorization includes:(5) physical and occupational therapy services, which includes those services listed in the Healthcare Common Procedure Coding System (HCPCS) at the following levels: (A) Level I code range for Physical Medicine and Rehabilitation, but limited to: (i) Modalities, both supervised and constant attendance;". The Carrier's denial is supported.
2. The requirements of applicable Division rules not met. No additional payment can be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is \$0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

Authorized Signature

_____ Signature	_____ Medical Fee Dispute Resolution Officer	_____ April 29, 2015 Date
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YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, 37 *Texas Register* 3833, **applicable to disputes filed on or after June 1, 2012.**

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.